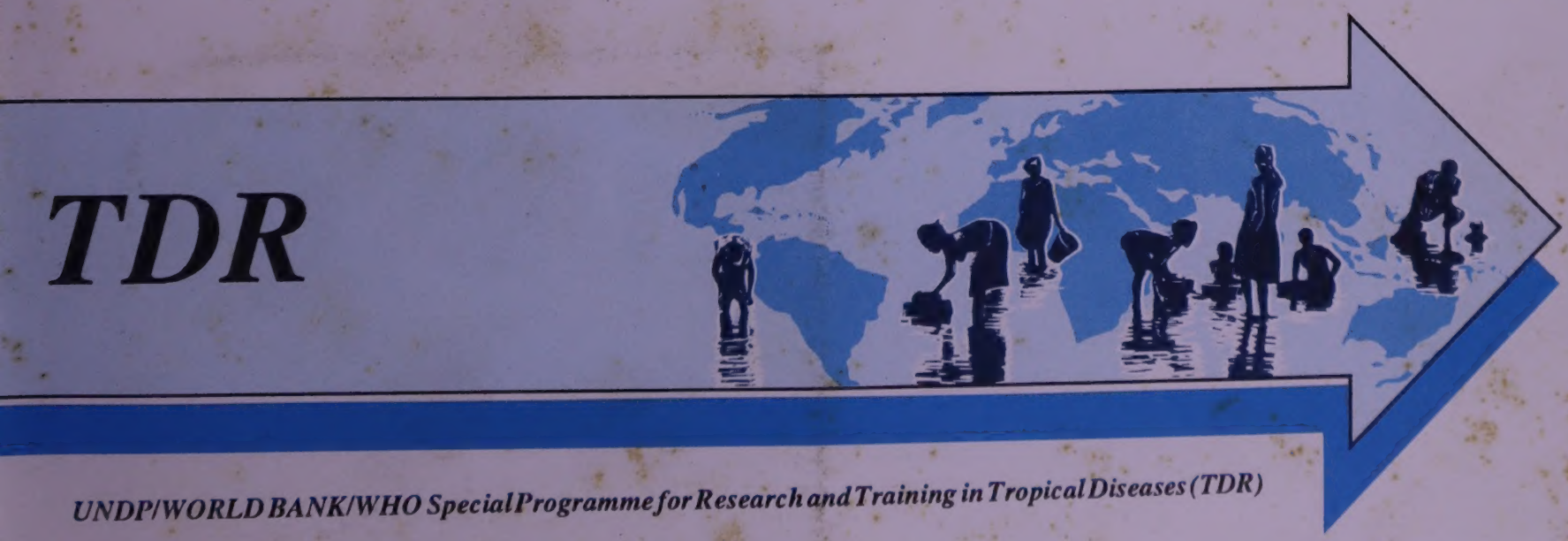
Social and Economic Research Project Reports *No. 14*

WHO/TDR Workshop on Qualitative Research Methods Report on the Field Work

by:
Kikwawila Study Group



UNDP/WORLD BANK/WHO Special Programme for Research and Training in Tropical Diseases (TDR)

04867

Community Health Cell
Library and Documentation Unit
367, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE-560 034.
Phone : 5531518

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08410

* The Kikwawila Study Group consists of the workshop participants and resource people listed in the Appendix

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SER Project Reports appear as part of a series of unedited final reports resulting from projects supported by the UNDP/WORLD BANK/WHO Special Programme for Research and Training in Tropical Diseases (TDR). These reports are submitted to the TDR Steering Committee on Social and Economic Research for review and evaluation upon completion of a project. Project reports included in this series have not been published in their entirety elsewhere.

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Foreword

The UNDP/WORLD BANK/WHO Special Programme for Research and Training in Tropical Diseases (TDR) is a globally coordinated effort to bring the resources of modern science to bear on the control of major tropical diseases: malaria, schistosomiasis, filariasis (including onchocerciasis), the trypanosomiases (both African sleeping sickness and the American form, Chagas' disease), the leishmaniases and leprosy. The Programme has two interdependent objectives:

- To develop new methods of preventing, diagnosing and treating selected tropical diseases, methods that would be applicable, acceptable and affordable by developing countries, require minimal skills or supervision and be readily integrated into the health services of these countries;
- To strengthen -- through training in biomedical and social sciences and through support to institutions -- the capability of developing countries to undertake the research required to develop these new disease control technologies.

The *Social and Economic Research Project Reports* series represents a communication venture undertaken by TDR's Social and Economic Research (SER) component. This series was launched in 1987 to facilitate and increase communication among social scientists and researchers in related disciplines carrying out research on social and economic aspects of tropical diseases and to disseminate social and economic research results to disease control personnel and government officials concerned with improving the effectiveness of tropical disease control.

Research reports published in this series are final reports of projects funded by TDR and usually include more material than ordinarily published in peer review journal articles. TDR considers this material to be valuable both for investigators involved in the study of social and economic aspects of tropical diseases and for professionals involved in training programmes in the social sciences, economics and public health. The series should acquaint those working on similar problems with approaches undertaken by others, in order to test new approaches in different settings, and should provide useful information to personnel in disease control programmes and related agencies.

Although SER, as of 1 January 1994, was integrated into an Applied Field Research (AFR) component of the TDR Programme, the AFR Steering Committee considers that the series deserves to be continued so that results of the social and economic research in TDR will continue to be disseminated.

In the interests of rapid dissemination of social and economic research findings, much of the supporting material, e.g., tabulated data, has not been included in the present report. This material is, however, available upon request to interested researchers. All requests for such material, citing in full the number, title and author(s) of the *SER Project Report*, should be addressed to: Dr C. Vlassoff, Secretary, Manager, Gender and Tropical Diseases Task Force, TDR, World Health Organization, 1211 Geneva 27, Switzerland.

Tore Godal, Director

Special Programme for Research
and Training in Tropical Diseases
TDR

Preface

This report represents a pilot project completed as part of a training workshop on qualitative research methods held in Ifakara, Tanzania in April, 1994. At the time of planning the workshop the fieldwork was seen essentially as a training exercise and publication of the results was not foreseen. However, the results of the fieldwork were so interesting that TDR decided to disseminate them as an SER Project Report, so that they could be shared with researchers, health planners and policy makers concerned with health seeking behaviour and its determinants at the community level.A sister report, documenting the techniques used at the workshop, including details of the teaching methods, samples of materials, and organization of the workshop, is also available (SER Resource Paper No. 3) from TDR.

The study represents one week of fieldwork involving 20 trainees. Techniques used were entirely qualitative, including observation, focus groups, semi-structured interviews and in-depth interviews. The data was analyzed by the participants at the workshop using a computer programme for qualitative data, Textbase Alpha. A draft report was written by the participants in Ifakara, and subsequently refined and edited in Geneva.

TDR would like to acknowledge the excellent collaboration of the Swiss Tropical Institute in Basel, and particularly Professor Marcel Tanner, in this initiative, and the hospitality of Dr. Andrew Kitua and his staff at the Ifakara Centre. We would also like to thank the medical assistants that gave freely of their time to help us with translation and field work. We owe a special debt of gratitude to the District Commissioner, Dr. P. Kangwa, the District Medical Officer, Dr. F. Lwila, the Mother Child Health (MCH) Coordinator, Mrs. G. Lubomba, and two teachers from Kilwawila village, Mr. Mawenge and Mr. Kisavuri, all of whom facilitated our visit to Kikwawila village and made our stay in Ifakara a truly memorable experience. We hope that this report will not only document that experience, but also pave the way for positive change in the health service offer in the area.

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CHAPTER 1

INTRODUCTION

One of the most useful tools of social science research is the application of qualitative research methods to identify factors inhibiting good health practices and the success of health interventions. Health problems have long been recognized as having a socio-cultural component, in addition to a biomedical one, and disease control and health related behavior is an area where social science research is often an effective method for developing health intervention strategies. These tools are particularly useful in an area of limited economic and medical resources such as rural Tanzania. When community health problems are assessed according to the community's needs and priorities, more effective strategies can be developed for empowering the community to address these problems on their own.

In addition to providing useful data for health providers, the study also served as an instructional model in qualitative methods for the researchers. As such, this report should be read in conjunction with the CSER research paper, which describes the methodology of qualitative research employed by the research participants. The researchers were sponsored by a collaborative effort of the Ifakara Centre, the Swiss Tropical Institute, and the Special Programme for Research and Training in Tropical Diseases (TDR). The following study examines the results from this workshop conducted from April 11-29, 1994 in Ifakara, Tanzania.

1.1 OBJECTIVES

Before interventions can be effected health problems must first be identified, the coping mechanisms explored, and the utilization or non-utilization of existing health services assessed. Thus, the specific focus of the research group emphasized four areas of study:

(i) Main health problems and health services;
(ii) Utilization of General health services;
(iii) Utilization of MCH (maternal and child health) services; (iv) Providers' perspectives on utilization of health services.

Through a combination of in-depth and semi-structured interviews, focus group discussions, and observation methods, researchers were able to collect data which will be useful in coordinating an effective health improvement strategy for the inhabitants of Kikwawila village in Tanzania or other similar villages throughout the country.

1.2 METHODS

The research team of 20 biomedical and social scientists was selected competitively from over a hundred proposals, and was comprised of participants from 17 countries in Africa, Latin America,and Asia (the majority from Anglophone Africa). Eight resource people provided assistance.

As a first step to introduce the village to the researchers, journal articles on research undertaken in the Kilombero district were reviewed by the group (participants and resource persons), with a view to gaining an insight into the life styles, dietary patterns and common diseases in the communities. Further background information on the district was obtained from guest speakers which included

the District Commissioner, the District Medical Officer, the MCH Coordinator in the area and two teachers from Kikwawila village.

In order to arm the participants with the required research instruments for the field study, they were exposed to lectures on the basic qualitative research tools such as In-depth Interviews, Semi-Structured Interviews, Group Discussions and Focus Group Discussions (FGD) and Observations. Lectures on the use of key informants, role playing and free listing were also presented.

Some introductory lectures on Textbase Alpha were given. Textbase Alpha is a programme that assists in organizing qualitative data for analysis. Participants were taken through different steps necessary to use the programme successfully.

The participants were divided into four groups, each with at least one Kaswahili speaking person, to facilitate the field work. The instruments for use in the field for each day were drawn up by the groups with the assistance of resource persons. These instruments were presented at the plenary sessions and necessary modifications were made. Each group was asked to use a different instrument each day for four days to examine the different health themes. Materials needed for field work included cassette tapes, recorders, batteries and sodas for Focus Groups. At the end of each field trip, a plenary session was held to discuss salient findings and problems encountered in the field. This enabled each group to benefit from the experience of the other researchers. At the end of each day the participants transcribed the data with the help of a translator and entered the material into computers using Text-Base Alpha.

The focus group participants were selected on the basis of purposeful sampling. Two focus groups were studied: the first comprising of traditional birth attendants (TBAs) in Kikwawila and the second of health workers (mainly nurses from an MCH clinic in Kibaoni). Both focus groups were comprised of seven participants. All participants were provided information about the study, how they were selected and how the results will be utilized. The focus group discussion was conducted through a Swahili translator and aided by cassette recording. This information was later transcribed and the results were entered into a Word Perfect 5.1 package, coded and stored in a Text-Base Alpha Programme and analyzed. A log book was also prepared to indicate the points of interest based on the code words.

The community was introduced into the field work in several steps as follows:

1. The authorities of the Kikwawila village (government and party leaders) were informed about the workshop and its field work part several weeks in advance. The director of the Ifakara Centre visited the village and explained the purpose of the study as well as outlined the field work.

2. Before the field work began the organizers visited the Kikwawila, Kapolo and lower Kilama parts of the village in order to meet the leaders such as the village secretary, the chairman, the great grandson of the founder of the village, Mzee Namkina, several ten cell leaders, teachers, health workers and numerous villagers. Again, the purpose of the workshop and its field work part was explained and an outline for the timing of the various activities was proposed in order to plan the field work activities outside the peak activity periods of the villagers.

3. On the morning of the first day of the field work, the organizers, with the resource people and the Kiswahili-speaking participants, paid a more formal visit to the Village Council Office to meet various village leaders and introduce key people from the workshop. These leaders included the Chairman, Secretary, CCM Party Secretary, and officers for Buildings and Agriculture. The arrangements for the work in each area of the village were finalized and the leaders agreed to accompany the research teams.

4. The last introductory steps were meetings of each research group within their part of the village where they would undertake the major part of the field work.

1.3 SITE DESCRIPTION

The research was conducted in the Kikwawila village, a very disperse settlement extending over 50 km^2 and representing also a transect of the Kilombero valley. This village has been the focus of a series of community based studies undertaken by the Ifakara Centre during the last 12 years. In addition, the village was also part of a health development programme in the 1980's resulting in the installation of village health posts, health education activities, treatment of most prevalent communicable diseases (malaria, schistosomiasis, intestinal helminths and protozoa) and an improvement of the sanitation and water supply systems.

The political community of Kikwawila village consists of four main settlement areas, Kapolo, Kikwawila, and lower and upper Kilama. The field work covered all health services in this area, including village health posts, dispensaries, traditional healers, MCH services (which includes traditional birth attendants) and the regional hospital.

The inhabitants of Kikwawila are poor. Many of them are farmers, growing maize, millet, rice, cassava, and sugar cane without the benefit of modern farm implements. A few are artisans. Some of the men leave home for weeks at a time to fish in the nearest river, returning in time to harvest rice or other seasonal crops. In addition to caring for their families, the women work in the fields as well. As in many developing countries the women of Kikwawila village work long hours on a variety of tasks, from cooking and cleaning, to gardening and farming. During the interviews one man stated frankly that one cause of the poor health of the women of the village was overwork. However, none of the women interviewed complained of their heavy load. The children wear ill-fitting clothes and most of them go barefoot.

The two predominant religions represented in the village are Islam and Christianity, with the majority of the inhabitants Catholic. There is large Catholic Mission in the area and the researchers speculated that its influence shaped family planning issues in the village.

The houses are made of mud and bricks; some have cement floors, all are poorly ventilated and dark. They have roofs of either thatch or corrugated iron and generally no ceilings. At the time of the research the houses were dry, but it was not the rainy season. Farm tools, kitchen utensils, and food stuffs are kept inside to prevent theft. The bedrooms are small and the bedding is often unclean. Bednets were scarce. Hurricane lamps provide light, as none of the villages are electrified. Water is typically stored inside the house in pots, which are not always covered.

The cooking area is outside the main house. The kitchen is usually a wooden structure or shed, with multiple stone stoves which burn wood or charcoal. Maize and millet are dried on animal skins or in metal containers. Near the kitchen, ducks and other fowls are kept in coops, along with an occasional goat. The compounds are clean and well swept with no weeds, and small gardens with tomatoes and peppers surround the houses. There are fruit trees in most compounds: banana, coconut, mango, guava, and cashews are grown in the area.

The organic waste is usually disposed of in an area at the rear of the houses which is filled with maize husks, skins, banana leaves, plastic waste, papers, etc. Pit latrines are also situated behind the houses, with and without pit covers, and typically an old sack serves as the door. The paths to the latrines are well marked and free of debris. The houses do not have individual wells, nor are there catchment systems to collect rainfall.

CHAPTER 2

MAIN HEALTH PROBLEMS

In discussing the main health problems encountered by the community of Kikwawila, maternal and child health issues have been put into a separate category. This was done entirely for organizational purposes. While this perhaps detracts from a holistic perspective on the health problems facing these villagers, the researchers felt that MCH issues represent a unique set of challenges which are best understood in their own context, apart from general health issues. Though to be sure, mothers and their children suffer from diarrhoea, malaria and the other health problems related in the following discussion.

Diarrhoea, malaria, dysentery, schistosomiasis, worms, skin and eye diseases, and hernias were considered by nearly all villagers to be their primary health concerns. Upon more focussed questioning, other diseases such as whooping cough, meningitis, anemia, STDs, respiratory infections, colds, epilepsy and convulsions completed the panoply of illnesses to which they are often subjected. Malaria and dysentery, sometimes in reverse order, were consistently cited as the two most serious health problems. Typically, schistosomiasis and intestinal worms were considered the next most serious health concerns, followed by, among men, hernias. For women, pregnancy related health issues were ranked high among their most common health problems.

In most cases these illnesses are understood by the community to be at least partly related to infrastructural failures. For instance, the lack of potable drinking water; the high water table which restricts in some cases the building of latrines; and the cessation of pool spraying were acknowledged as primary causes of schistosomiasis, diarrhoea, and malaria.

Focus group discussions among the villagers found a high degree of knowledge about the causes of the more common illnesses. Nearly every respondent knew the source--and the necessary treatment-- of the most prevalent diseases, though they admitted, in some instances, a failure or inability to modify behavior to prevent them. The two most prominent exceptions were hernia and cerebral malaria (dege-dege), which seemed to them to have no specific etiology. The distinction in this village between generalized malarial symptoms (fever, chills, weakness) with its known vector (mosquitoes) and cerebral malaria, accompanied by convulsions and of uncertain etiology, is a subject that needs further study.

2.1 OVERVIEW

The following overview, which was drawn from the interviews conducted by the researchers, is designed to give the reader a concise look at the most common diseases, community awareness and knowledge, and specific coping mechanisms employed. In some cases researchers noticed gender discrepancies in knowledge or treatment behavior; vis a vis specific diseases, and where important, this is noted.

Again, maternal and child health issues are discussed in depth elsewhere, in chapter 4, and are not discussed in the overview except in very general terms.

2.2 MALARIA

There is widespread knowledge in the village that the malaria parasite is carried by the mosquito, specifically the anopheles variety, and that standing water and pools are breeding grounds for the

insect. As for diagnosis, the symptoms are painfully evident from the response by one informant: "A person starts having chills and aching limbs, and even on a hot day like this he can literally sit in the sun but still feel cold. When this happens, one knows for sure he has malaria."

Preventing malaria is made difficult by a lack of resources. For example when asked how does one prevent malaria, a respondent replied: "Those who can afford are using bed nets. Once you get a bed net, you won't get malaria." Another added, "But we are not able to buy the nets." In support of this, the researchers found very few bednets in the homes they entered, particularly in homes with large families. Mosquito coils were considered ineffective: "Even the mosquitos are used to it," one said. The village no longer sprays the puddles and ponds and insecticides are too expensive for home use. Often women will burn maize cobs and rice husks to smoke out the mosquitos from the homes at night. The use of chloroquine as a malaria prophylaxis is recognized as ideal but impractical due to the cost and scarcity of the drug.

Upon onset of malarial symptoms most villagers reported the utilization of modern services such as a local dispensary or the main hospital in Ifakara. These services provide blood tests and can confirm the presence of the disease accurately. Men, particularly, will seek treatment for malaria at these locations. However, drugs are often scarce, and recourse to hospital registration and diagnostic fees sometimes necessitate alternative treatment. Several women, when questioned further, reported seeking treatment from a traditional healer, often as an interim strategy, while they saved money or recovered the strength necessary to travel to the hospital.

This concept of parallel utilization of modern and traditional health services is seen quite often in the health seeking behavior of this community and is discussed in detail later. Furthermore, for malaria particularly, there is evidence of self-medication. Some anti-malarial drugs are occasionally available in general stores or from street peddlers and several women reported their use for mild cases.

Interestingly, cerebral malaria, or "dege-dege," which often afflicts the young, is treated quite differently by most members of the community. As convulsions are the most dramatic symptoms of this form of malaria, the disease is considered distinct from standard malaria, and in nearly all cases treated by a traditional healer. Convulsions, whether from dege-dege or epilepsy, are considered supernatural in origin and thus out of the realm of modern diagnostic science.

2.3 DYSENTERY

Dysentery is acknowledged uniformly as a serious disease requiring prompt intervention. In every survey dysentery was ranked by villagers and health care providers as one of the two most serious health problems they encounter.

When asked which preventive measures they take against dysentery, all of the respondents felt the community could effectively prevent the disease if clean sources of water were available to them. In lieu of that, they recognized they could still prevent the disease through boiling water before use. Further, most women emphasized increased hygienic measures such as care in cleaning cooking utensils and utilization of clean, covered latrines.

There was consensus among participants with regard to where people in the community go for treatment of dysentery: St. Francis hospital in Ifakara. The hospital, it is felt, is capable through laboratory examination of distinguishing between dysentery and the diarrhoea which often accompanies other intestinal disorders. Further, it is the only place where a patient can receive

infusions to prevent the often fatal dehydration which results from dysentery. When asked if traditional healers were capable of treating dysentery the answer was uniformly negative.

2.4 SCHISTOSOMIASIS

Urinary schistosomiasis, indicated symptomatically by bloody urine, is known to result from contact with the snails which live and breed in the ponds and rivers that are found in the region. There is a high degree of knowledge regarding this disease among the village because of an ongoing schistosomiasis research program in the area, funded by the Swiss Tropical Institute. In fact, there is a local name for the disease in Kaswihili, "kichoco," which indicates its importance to the villagers.

There is a strong feeling that provision of piped treated water would be a long term solution to schistosomiasis infection as it will keep the mothers and children from the ponds where they fetch water, wash clothes, and bathe. In Lower Kilama one woman noted " there are only three taps and we are many. That's why we are drinking water from the wells. As a result we are getting schistosomiasis." Sometimes children will swim or bathe in ponds where there are snails present. One woman said "it's difficult to control the children. Even if you boil the drinking water and provide hot water for bathing, they will go to the ponds...They pretend to go and look for some fish and they swim and get the disease."

There was a consensus among the respondents that people go to the hospital for treatment of schistosomiasis since the traditional healers are not known to have an effective cure for this disease. Neither are the local dispensaries or village health posts able to treat the disease. Thus, whenever blood is passed in urine one goes to the hospital immediately.

2.5 OTHER INTESTINAL HELMINTHS

The rainy season elevates the water table which hinders the digging of latrines, increases the number of standing pools, and spreads malaria, schistosomiasis, and worms. Intestinal helminths are indicated by several symptoms: diarrhoea, constipation, stomach pain and swelling, loss of appetite, and malaise, to name a few.

One woman, a mother of four, reported that hookworms (safura) were the biggest health concern for herself and her children.

> Your stomach swells yet you have not eaten anything the whole day. Your ears ache and it feels like people are playing drums inside your ears and your eyes can not see well. When you are walking your joints have no energy.

When she suspects hookworms she seeks treatment at St. Francis hospital where the illness can be diagnosed properly and medication provided, though the cure, on an outpatient basis, may take days. In addition to the hospital, the dispensaries also have laboratories which are capable of analysing stool samples for worms and other parasitic helminths, though they may not have drugs to cure them. Traditional medicine is rarely sought for worms, according to the respondents.

Hookworms and several other parasitic helminths can be prevented, the respondents knew, by wearing shoes. But again, well-soled shoes are expensive. One man held up his sandal and remarked ruefully that one needed shoes that covered the foot properly, "not like my sandals which have a hole as you can see." The use of clean, covered latrines is another measure which is recognized as preventing worms, but due to high water tables pit latrines are difficult to dig and maintain, and it is not uncommon to defecate in the bush.

2.6 DIARRHOEA

Diarrhoea is a symptom of a variety of diseases and is recognized as a serious health problem on its own. Bloody diarrhoea is seen as a killer of children particularly and spreads rapidly within a family, requiring medicine for everyone. Boiling water and general hygiene are recognized as important steps to prevent diarrhoea and treatment from modern services for persistent or severe diarrhoea is considered essential. However, there are some practical and cultural impediments to boiling water, which is time consuming, requires the gathering of fire wood, and demands a certain degree of planning. "To be truthful, we don't like to drink hot water," one woman admitted. Furthermore, the water the children drink at the schools is often untreated, and it is difficult to teach children to drink only pre-boiled water when they are hot and thirsty.

Dehydration, which is known to accompany diarrhoea, is sometimes treated at home until modern services can be utilized. One mother described her own "oral rehydration packet" as boiled water with sugar and salt added, which indicated, at the least, a working understanding of the body chemistry affected by diarrhoea and how it should be treated.

2.7 SKIN AND EYE DISEASES

Scabies and eye diseases (conjunctivitis) were listed by both men and women as a serious health concern. With scabies, the female respondents felt that general body cleanliness, including the washing of clothes, is the most effective preventive measure against the disease. Again, preventive measures were limited by the availability of clean water. Special medicated soaps can be purchased at local dispensaries or general stores, but in many cases the rashes continued, sometimes accompanied by fever, and eventually a trip to the hospital is often required.

The villagers were aware of several herbal treatments for scabies and eye diseases which occasionally had at least a palliative effect, if not a cure. For eye diseases, for instance, washing of the eyes with water from boiled tea leaves, water from soaked tomato leaves or boiled water with salt were considered effective. Traditional methods are often utilized for these illnesses and traditional healers purport some knowledge of effective herbal remedies.

2.8 HERNIAS

Hernias were listed by many men as a serious health concern, consistently listing the condition among their top five health problems. Here, the men surveyed were less knowledgeable as to the cause of hernias than for most other health problems. Because the etiology of the condition was unknown to them they saw no way to prevent its occurrence. Most of the agricultural work is done by hand and possibly lifting the farm implements, particularly when one is weakened by malaria or other illnesses, is the source of the many hernias they report.

Treatment is sought either at a hospital or a traditional healer. This parallel utilization results from a lack of understanding of the cause of hernias. For example, some respondents believed hernias resulted from a curse brought on by trespassing or taking someone's property by mistake. In this case, a traditional healer is employed to remove the curse. Other respondents report they go directly to a hospital when a pain in the groin occurs, believing only surgery will alleviate their condition.

2.9 AIDS

Although much of Africa is suffering from an AIDS epidemic, this particular region has, so far, remained relatively unaffected. There are reports of AIDS sufferers coming home from Dar Es Salaam or other large cities to die, but certainly HIV penetration in the community at large is, for the moment, limited. However, the prevalence of other STDs, notably gonorrhoea, indicate at least the possibility of transmission of HIV into the general community sometime in the future, especially given the low level of knowledge about the disease in the village.

2.10 OTHER HEALTH PROBLEMS

Upper respiratory infections, colds and flu, meningitis, anemia, and STDs are commonly occurring health problems in the area as well. Aspirin and antibiotics are occasionally available at dispensaries to treat these illnesses, but in some cases traditional medicines are used. It should be noted that STDs were mentioned only by men as a health problem, and were not mentioned spontaneously. This is perhaps due to stigmatization of the disease. However, health workers frequently listed gonorrhoea as a disease they commonly treat, adding that the patients almost never bring their partners for additional treatment.

2.11 EVALUATION

Overall, there were some measurable differences in disease perceptions between men and women in the village. From the focus group discussions it became clear that men tended to look at diseases in terms of their own experiences, rather than from the village perspective. In contrast, most of the female respondents indicated knowledge of diseases affecting not only themselves, but those which affected mothers, children, and the elderly.
This difference may arise from the fact that women in most African communities are tasked with the health care role for the family, thus they are more conversant with the many types of disease which affect their community.

There were also obvious differences between men and women in terms of health seeking behaviour. For example, when asked where they sought health care for the most common diseases male respondents were quick to mention hospitals as an immediate source of care. It was only after a series of in-depth probing that other sources of care such as traditional healers or local home remedies were mentioned. The female respondents, on the other hand, were more forthright in mentioning the home remedies and other therapies that are typically taken for some diseases before seeking modern services.

CHAPTER 3

HEALTH SERVICES

The following discussion of modern and traditional health services will give the reader an idea of the health seeking opportunities available to the community. The researchers visited dispensaries, health posts, the hospital, and several traditional health compounds in order to assess the type and quality of service offered. The researchers interviewed patients and health providers, and they inspected registries and other records to evaluate each particular service. Questions concerning cost of treatment, length of visit, referrals, and patient satisfaction were asked in formulating their report.

3.1 MODERN SERVICES

As its description above indicates, the poverty of Kikwawila village and the lack of infrastructure contribute to the health woes of it's inhabitants. The road to St. Francis Hospital in Ifakara is poor and occasionally flooded, and the hospital itself is as far as twenty kilometers from one of the areas studied. To reach the hospital patients must walk or ride a bicycle; if non-ambulatory sometimes they are carried in wheelbarrows. The four villages that comprise the study area are not electrified, and in some cases the water pumps which had been supplied during the 80's were in disrepair, leaving the community to rely partly on shallow wells or natural water sources, which contributes to poor health.

The lack of drugs was listed by community leaders, patients and health care providers as the single greatest impediment to providing quality health care for the community at large. In many cases patients seeking modern services face the daunting and frustrating task of finding on their own the drugs for which they have prescriptions. Paying for these drugs, which are sometimes expired, is another difficulty. Ill patients must often walk long distances, back and forth, between health posts, dispensaries, hospitals and drug shops before beginning their treatment.

In the description below the lack of drugs and modern equipment is frequently cited, perhaps to the point of appearing redundant. It is hoped the reader will accept this repetition as the most telling aspect of the pervasiveness of this problem.

3.2 KILAMA VILLAGE HEALTH POST

The village health post in Kilama is a small, two-room structure with a corrugated metal roof. It is staffed three times a week for only a few hours in the morning. The researchers found empty bottles of antiseptic and aquaflavin on the floor and little else. A wooden medicine box contained one bottle of chloroquine phosphate and several oral rehydration packets, along with a few rolls of bandages and a roll of cotton wool. Although there was a health register the last entry was made two months previously and the researchers presumed that this date indicated the last arrival of drugs. The village health worker seemed demoralised and many villagers didn't trust him. Some speculated that he passed on the drugs to his family or friends. One villager scoffed at the idea of visiting the health post at all: "We cannot say we have a health post, but we have a small house (which is) not for health services."

Another echoed his sentiments: "It is just a house. It is our house, we go and see it, but there is nothing there." When asked if doctors were available there, he replied: "They are going there, but we don't know if they are doing any work."

3.3 KIBAONI DISPENSARY

In a similar pattern the Kibaoni Dispensary is poorly maintained and often without drugs. Examination of the registry files indicated the expected correlation between availability of drugs and the number of patients seen. When drugs are available it is not uncommon for the dispensary to receive one hundred patients a day, but this dwindles to thirty or forty when drugs are scarce. According to the health workers, the most common diseases treated at the dispensary were malaria, upper respiratory tract infections, diarrhoea, and gonorrhoea. The majority of the patients are children who are brought there by their mothers.

The Dispensary provides laboratory services which cover mainly blood, urine and stool investigations. Laboratory results can be obtained in a day. The presence of the laboratory seems to add some credibility to the dispensary's service. The patients interviewed accepted the diagnoses, which are performed in one day, quite well.

There is a good referral system at the Dispensary. Most referrals are made to St. Francis Hospital in Ifakara. For instance, when a child is brought in with severe malaria, he/she is given a valium injection and sent to the Hospital.

The researchers interviewed a medical aide from the Kibaoni Dispensary in order to get her perspective on the health problems of the community and the services the Dispensary offers. She had worked as a rural medical aide for six years and was trained at Mtwara for three years after she completed Form 4 (secondary school).

When asked what equipment she felt the Dispensary needed, the aide first listed cleaning equipment, e.g., brooms and knives to cut the grass outside, then moved to a more generalized statement: "We have shortage of almost every necessary instrument for providing health services." She blamed the poverty of the community for the persistence of many of the diseases they face; the lack of bednets, for instance, perpetuates the many malaria cases they treat. Often there is no wood to burn so that water is drunk unboiled--despite knowledge in the community about the dangers of unboiled water.

Regarding the integration of traditional healers and TBAs with the dispensary's service, the aide felt that their role was beneficial to the community and the dispensary should be engaged in continuing their training in modern diagnostic methods.

According to the aide, there is not much support from the community for the Dispensary. The people do not consider the facility their own, believing, instead, that it belongs to the district authorities, so there is no support for maintaining and cleaning the facility. They have nothing to do with it apart from attending it when they are sick.

3.4 BAKWATA DISPENSARY

This dispensary, which is privately owned, is a small five room house lit by a hurricane lamps. The only examining tools were a sphygmomanometer, a stethoscope, and a bed with no screen. On the morning the researchers visited the dispensary had thirty patients, primarily women, but often, they were told, the dispensary was busier. There is a "laboratory" which has an old compound microscope, though it is staffed by a trained technician. He performs tests to check for malaria, worm eggs in stool, and skin snips for onchocerciasis (river blindness).

Drugs, when in stock, were dispensed on site and injections were performed with needles sterilised over a kerosene stove. If one could afford it, new syringes could be purchased, but otherwise old ones were used. The dispensary seemed to enjoy a more regular drug supply than others and

received and supplied many patients from the hospital at Ifakara. Patients paid for their treatment and laboratory work, about 50 T.Shs. for samples and 300 T.Shs for medication.

Patients interviewed there considered the service good. This may be attributed, in part, to the lack of a marked difference in the social status of the providers and users and the availability of drugs.

3.5 SHOPS AND DRUG PEDDLERS

Most of the communities have small general stores where some drugs can be purchased, along with food staples and other sundry goods. Because the main shopping centre is in Ifakara, hours away on foot, these shops receive a high customer count. In addition to food items the shops generally supply some drugs. In one typical store, researchers found panadol, hedex, malaraquin, homaquin, and Cafenol on the shelves. Medicated soap is available as well. The quantities of these drugs are limited, however, and often the drugs have expired by the time they reach the buyer. Furthermore, the shop owners have no expertise in dispensing medication and are unable to provide dosage information. While it is certainly convenient to have drugs available in these stores, there are health risks to be considered. The researchers found a growing tendency toward self-medication in the community to avoid the expense of hospital treatment and to save time as well.

Drug peddlers were reported in some of the villages, but the research team did not interview them. It was uncertain where the peddlers received their drugs, perhaps from other health workers in illegal transactions. Corruption of some health care workers, eg. giving drugs to friends or family members, was mentioned by some community members but not proven. With the unreliable drug availability in dispensaries and the hospital, along with the great distances a patient must travel, often on foot, to reach them, it is easy to see why black market drug peddling might find a niche in the area.

3.6 ST. FRANCIS DISTRICT HOSPITAL

This is the main hospital in Kilomero district and has six wards, including facilities for sonography, radiology, and surgery. The registration fee is 200 T.Shs and the waiting room which comfortably seats fifty is generally full. Drugs are not always available, and it is not uncommon for a patient to be given a prescription, told to find the drugs elsewhere and return for treatment. The district which St. Francis serves is spread out over fifty square kilometers, and from the smaller outlying communities a trip to the hospital is arduous and not taken lightly. Still, St. Francis is considered the only viable modern treatment center for serious cases of even the most common diseases. Ironically, in some cases when treatment fails here, or if drugs are too expensive or not available, patients may resort to traditional healers.

In the past hospital treatment was free. Now, there is a registration charge and patients must pay for laboratory work and prescriptions. However, though many patients have difficulty paying for their services, some respondents mentioned improved service as a desirable outcome of the new fee system. One respondent implied that, formerly, hospital workers expected gifts or bribes. Now, with everything above board, those pressures have been eliminated and service has improved.

The researchers found anecdotal evidence of discrimination by the health providers toward more elderly or poor villagers. One man complained that the way he was dressed influenced his treatment:

> If we dress poorly costs are sometimes reduced, but when we get to the pharmacy because of the reduced price, you are told there are no drugs. However, if you are relatively well dressed you are charged more but given all the drugs you need."

Women often face additional pressures in the form of sexual harassment when seeking treatment from some of the modern health services. Several women mentioned being propositioned for sexual favors in return for drug prescriptions or treatment for their children. The following quote is illustrative:

> These men doctors are very troublesome. When we ask for medicine they tell you that they love you and will we meet them in the evening? What can you do when the child is sick? That is why some of us accept and some us will not accept. Without this you won't get medicines...we need female doctors.

3.8 TRADITIONAL HEALTH SERVICES

Traditional healing services are sought when modern services are considered fallible, too expensive, or useless. In some cases traditional healing is seen as provisional care until modern services can be employed. On the other hand, traditional healers are often seen as providing "the last chance" in cases of extreme illness where modern services have failed. Most often, however, traditional healing falls between these two extremes, and is utilized, along with modern services, as a parallel health system.

According to the focus group discussants: convulsions, epilepsy, and dege-dege are generally considered best treated by traditional healers; perhaps in part, due to a poor success rate at the hospital. In some cases, minor attacks of the more common endemic diseases, eg. conjunctivitis, scabies, rashes, may be treated traditionally as well. Traditional healers are usually conversant in herbal remedies which are often effective in treating these ailments.

The research team found little evidence of gender bias when seeking traditional healing. Both men and women utilize it to some degree; others disdain their service altogether, calling the healers "cheats." Educational levels are perhaps the better gauge for determining who seeks traditional services.

The healers are usually men, and their expertise is considered supernaturally inspired; hence their treatment is often sought for diseases which seem to have a supernatural etiology. For example, traditional healers are sought when a disease is thought to have originated from a "bad deed." For the treatment of hernias traditional services are sometimes sought because hernias seem to appear spontaneously, as if from a curse. Cerebral malaria (dege-dege) is often treated traditionally, while standard malarial symptoms typically lead one to a modern health facility.

3.9 A TRADITIONAL HEALER

The research team performed an in-depth interview with a traditional healer from the village of Lower Kilama who had been practicing for eight years. He was 31 years old, married and had two children. He had received no formal training. As a young man his healing talents manifested themselves after he suffered a high fever and a headache. In his dreams ancestors spoke to him and allowed him to predict the future. Now the spirits tell him what to say and do regarding his patients. If their instructions are not followed the healer says he may be punished or even beaten. His paternal grandfather had undergone a similar experience and become a healer as well.

The healer claimed an ability to treat a broad range of illnesses: headache, family problems, eye diseases, paralysis, diarrhoea/abdominal pain, infertility, malnutrition, schistosomiasis, gonorrhoea, AIDS, ulcer, skin diseases, coughing, impotence, and dental problems. "In fact, all problems that disturb human beings."

When asked which diseases he most successfully treated, the list was shorter: mental illnesses, spiritual possession, epilepsy, paralysis, family problems, acquired blindness, malaria, and infertility. When asked which diseases he could not cure he listed: TB, leprosy, and AIDS.

He sees an average of five patients a day, though ten is not uncommon. He provides in-patient treatment, typically for patients who have failed to receive "cures" from the hospital. His wife assists him in treating the in-patients. He charges no specific payment. Patients are asked to pay transport costs incurred in looking for the herbs which are used in their treatment. Some pay in kind, providing labor, while patients with mental problems are asked to pay 4000-5000 T.Shs. His services were free in the past, but now the herbs have become expensive to locate.

When asked his concept of disease causality the healer exhibited some knowledge of modern disease etiology. For example, he identified the plasmodium of the anopheles mosquito as the cause of malaria. In contrast, he also listed spiritual possession as a cause for mental diseases and convulsions. In addition to demonic possession, he stated that marijuana and alcohol consumption also contributed to mental illnesses.

The healer refers patients to other healers or to modern health services if he fails to cure them. He purported to be open to instruction in modern medical techniques to complement his traditional methods. When asked to list items which might improve his service he named several modern diagnostic tools including a blood-pressure monitoring equipment, blood examination equipment, and a sterilisation kit, which indicates a desire to bridge his services with the hospitals and dispensaries with which he competes.

3.10 TRADITIONAL HEALING CLINIC: A DESCRIPTION

The clinic of this traditional healer in Kilama village is quite large and has one main healer along with four assistant healers, including the main healer's wife, and three helpers. His clinic began operation in 1990. The clinic includes a kitchen for the preparation of healing foods, along with separate wards for men, women and children. There are twenty-seven beds available but only four bednets were counted.

There seems to be good interaction between the staff and patients. Some patients pay for treatment by working for the traditional healer on his farms or on the compound. Some patients even go and collect herbs from the bush. There is therefore no shortage of traditional medicines.

The clinic is a large compound with brick, mud and thatch houses with thatched roofs. In addition to the wards, there is a reception room, a training room, and a consulting room. The consulting room was in the same building as the women and children's ward. The floor was covered with mats and there were two stools. There were bottles of colorless liquid on a table in the consulting room. At the centre of the table there was a flat woven container with various shells. A talisman hung on a wall, and there was also a black goat skin and two fly whisks ('nyumbu') which are purported to be used for diagnosis.

The women and children's ward is a thatch structure with 13 beds and two bednets. The brick ward had eight beds with no bednets. The male ward had six beds and two bednets. The beds were all neatly covered with colourful fabric. One male patient was found in bed with swollen limbs and he appeared weak and listless. The women and children patients were quiet withdrawn and sickly. Their hair was either trimmed short or completely shaved.

The reception room is located near the healer's uncompleted house. It is made of thatch and has six chairs. The room is also used for the training and re-training of healers. There were about 15 women, six men and five children sitting in the shade of the ward.

Despite the occasional criticism of traditional healers and their practices, it is clear they play an important role in the health of their community. Whether their services are sought first, for minor ailments, or as a "last ditch effort" to save a life, their status in the community is relatively high and stable, as indicated by the size of the compound described above. In an area such as Kikwawila village, where modern health facilities are some distance away from smaller villages and often under-supplied, the traditional healer's role in maintaining the health of the community should not be underestimated.

CHAPTER 4

MATERNAL AND CHILD HEALTH SERVICES

The maternal and child health services in Kikwawila come from three sources: the traditional birth attendant, who may or may not provide ante and postnatal care and instruction; the MCH clinic in Kibaoni which does provide ante and postnatal care but not delivery; and St. Francis hospital in Ifakara which provides delivery services, as well as ante and postnatal care, though at a higher cost than the traditional birth attendants (TBAs).

The researchers interviewed several TBAs, as well as groups of young mothers in the region and service providers from the MCH clinic in Kibaoni to get a clearer understanding of the health needs for mothers and their children. Independent observation, focus group discussions, as well as semi-structured interviews revealed the decision making strategies employed by these mothers regarding their deliveries and the health of their children.

4.1 DELIVERY

The researchers found the same infrastructural impediments which restrict seeking health care in the general population confronting mothers and their children as well. For instance, nearly all the mothers surveyed indicated a preference to giving birth at St. Francis hospital, particularly for the first and second child. However, if labor commences in the evening, in most cases TBAs were called in to the mother's home because transportation to the hospital at night, particularly from an outlying village with primitive means of conveyance, was too difficult. Sometimes the women are carried on stretchers. "We carry them on beds, like dead bodies," said one man. One woman added: "Sometimes they carry you on the wheelbarrow they use to carry charcoal. They carry you as if they are carrying a sack of charcoal." Respondents spoke of women who had delivered on the way to the hospital as well:

> The woman is carried by the men and then delivers along the way. It is very shameful. When the condition is serious, we ask them to stop the stretcher and then you deliver your baby and carry it to the hospital.

The risks of delivering en route were well acknowledged:

> When one delivers on the way, sometimes the baby may drink the dirty water (presumably while being washed). The baby may die and even the mother too.

4.2 COSTS

The cost of hospital delivery is considered another obstacle. One MCH aide from the clinic at Kibaoni said the hospital delivery rates had been raised to 2500 T.Shs. She anticipated an increase in maternal mortality because mothers would hesitate to seek delivery there at such a high cost. There was anecdotal evidence of mothers running away with their babies without paying, and in response the hospital was said to have introduced a policy of keeping the babies and demanding on-site breastfeeding until services were paid.

4.3 TRADITIONAL BIRTH ATTENDANTS

Although the TBA plays an accepted role in village life, most of the respondents felt that they were not adequately trained or capable of providing adequate care for anything but routine deliveries. In one interview three mothers mentioned women who had died as a result of complications, such as excessive bleeding, which the TBAs could not handle. The TBAs interviewed acknowledged their limitations and insisted that difficult deliveries, particularly first births, were always referred to the hospital whenever possible. Regarding first births one TBA said forthrightly,"If it is the first birth, whether they say that they won't reach the hospital, I tell them to go." Another TBA echoed her sentiment: "Only those with many deliveries, three or four times when they complain they won't reach the hospital, I help them. But no for the first pregnancy."

In some instances when a woman enlists the aid of a traditional healer to help her conceive she will go to the same traditional healer to deliver. He can provide herbs to prevent spontaneous abortion or, later, to ease labor pains. After delivery, the mother will stay for seven days while the traditional healer performs rituals and then releases her. The mothers seem to derive some psychological benefit from these practices, though they do not fall under the rubrik of standard post-natal care.

The reader should recall that the villages are not electrified; therefore, any delivery which takes place at night in a village is illuminated only by hurricane lamps. Typically, the TBA brings to the delivery a lamp, a basin and/or clean cloth for reception, and a razor blade. In some cases, the mother provides her own razor blade to ensure sterility. Payment to the TBA is occasionally a bar of soap with which to clean herself, though in many cases they are not paid at all, but provide their assistance out of sense of altruism. Frequently, they receive little or no gratitude for their work as well, and this is a painful indication of their uncertain status within the village community.

Outside the community, however, MCH aides often praise the TBAs for performing a crucial and delicate role. The aides suggested that further training and attention to the needs of TBAs would greatly increase the health of mothers and their newborns, as well as provide important status to the birth attendant.

4.4 DELIVERY WITH A TBA

During the delivery, the TBAs watch for the appearance of the baby's head, then receive the baby when it emerges and lay it on a "clean cloth" or in a "good basin". Both TBAs interviewed said that they cut the umbilical cord with a clean razor blade. They were very clear on the importance of using a new razor blade in order to prevent infection of the cord and diseases in the newborn such as tetanus. After the afterbirth is buried, the mother is cleaned and the birth is recorded, usually as a knot on a string. The mother is then counseled to visit the MCH clinic as soon as possible for vaccination and further postnatal training.

4.5 TRAINING

The TBAs interviewed had received formal training from other TBAs within the village, or in some cases from their mothers who were TBAs. Most of them performed a kind of apprenticeship by attending births with more experienced TBAs until they felt comfortable on their own. Along the way many of them had received some formal training at St. Francis hospital, but some of them felt the courses were repetitive. Others professed a desire to attend more formal training courses, but there is sometimes poor coordination between the modern health services and the traditional attendants. The following description of a TBA from Upper Kilama is illustrative:

This TBA was trained by her mother who was herself a TBA. The mother trained all of her four daughters in the profession. This TBA began training after her third child was born and apprenticed with her mother for two months. She became comfortable on her own after assisting in four deliveries.

In 1991 the TBA had further training at St. Francis Hospital in Ifakara which lasted one month. She felt the training was redundant, covering things she already knew. She did learn how to keep birth records by tying a knot in a string after each delivery.

When this TBA realizes that a pregnant woman may have problems during delivery, she advises her to go to the hospital or the clinic. She makes this diagnosis through interviewing the pregnant woman to find out about her problems. She does not provide ante or postnatal care, though she does refer the mother to the MCH clinic for vaccinations.

There has not been much contact with MCH personnel since completing training. Since 1991 the TBA had only three visits to the MCH clinic at Kapolo. The purpose of these visits has been to give an account of the number of deliveries she had assisted after the last visit. The TBA currently has a basin and a broken hurricane lamp for services. She has an old blade which she cleans before she cuts the umbilical cord. She has a string to help her keep track of the number of deliveries she assists. Deliveries normally take place in the houses of the expecting women. Since 1991 she has assisted in nine births, the last in February of 1994.

4.6 STATUS OF TBAs

The relationship between the expectant mothers and the TBAs is complex and variable. Most of the TBAs feel unappreciated; their services begrudgingly required and often not paid for. "People we help never come back," said one TBA. "To avoid payment they rotate. Once they go to one TBA, next pregnancy they go to another."

Because most TBAs do not provide antenatal services they do not establish a rapport with the expectant mothers. As such, their services are often provided ad hoc: "When a man comes to me and says that my wife is in labor pain and we are not able to go to Ifakara, so we beg your help."

Since most TBAs prefer not to attend to first pregnancies and refer these women to the hospital, on subsequent pregnancies, their services are inevitably compared to the hospital deliveries and perhaps found lacking. One TBA described the unsatisfactory relationship with mothers this way:

> What kind of relationship would we have with her? They never come back. They come, they knock on your door, we prepare everything--tea, a good bed, and after delivery they never come back. They are not ashamed? It is up to them. That is why they go to another TBA, they are ashamed to come back to us. Because if they come back, we may say, 'Ah, today, we have no kerosene.'

Another TBA found her job satisfying because "it's a duty to fellow women," and she felt she was saving lives. However, this woman had some knowledge of traditional healing as well, and perhaps her status was somewhat elevated in her village (Lower Kilama) because of that.

All of the TBAs interviewed felt they required more equipment to improve their services. Gloves, scissors and razors, and gauze were listed as items they desired. In some cases they needed new lamps and new basins for receiving the baby. Some asked for more training, specifically from modern delivery services.

The two TBAs who were interviewed in depth said there was presently no contact between themselves and health workers. They are both interested in being trained in midwifery techniques and learning how to deal with more difficult deliveries. One of the TBAs was called for midwifery training in Kapolo, but there was some error in communication and when she arrived, the training course was completed. She was informed that she would be called at a later date for training, but this never happened.

4.7 ANTE AND POSTNATAL CARE

In Lower Kilama the village health post closed at the end of 1993. Until then mothers could have their babies weighed and given anti-malarials there, now they must go to the MCH clinic in Kibaoni; the Kibaoni dispensary, which may not have drugs in stock; or to the hospital in Ifakara for treatment.

Nearly all of the mothers interviewed report following the MCH policy of seeking postnatal services one month after delivery, and found it helpful for their children: "Yes, it was helpful... because it helps me to see how the child is growing" or "how to feed the baby".

The research group conducted interviews in Kikwawila with several young women of child bearing age to learn more regarding their ante and postnatal health practices. The following is part of an interview with three mothers, each of whom had three or more children.

Q: What do you do to ensure all is well with your pregnancy?

R.1: We are attending MCH clinic for investigations. We are not doing hard work.
R.2: We are not doing hard work when the pregnancy is seven months. We are trying to relax after working by sleeping or sitting. We are following instructions given at MCH clinic by the nurses. For example, to report when we are sick. In case we have malaria we are supposed to report it immediately.
R.3: It depends on whether or not one conceives through the services of traditional healers or naturally. In case of traditional healers you have to follow the given instructions and taboos. Examples of such taboos are: 1) You must not eat eggs. 2) You must not sit on the doorway. 3) You must not drink water when standing. 4) You must not tie any belt around the waist. 5) You must sleep or go out with another man. Then the traditional healer gives some herbs that the patient takes throughout pregnancy. If the pregnancy is conceived naturally then one goes to the MCH clinic.

Q: At what stage of the pregnancy do you start to use the services mentioned?
R.1: We have been told to start clinic when pregnancy is three months old.
R.2: I started at four months.
R.3: I started at five months.

Q: For how long do you continue to use these services?
R.1: We go regularly throughout the period of pregnancy.
R.2: If the pregnancy was conceived through the assistance of traditional healers, they also use the services and herbs of the traditional healers throughout the period of the pregnancy.

Another interview in Kikwawila with less experienced mothers reflected similar practices. The respondents all visited the MCH clinic regularly throughout their pregnancies. Most said they had learned some maternal and child health in school, and had learned then to go to a MCH clinic when

pregnancy occurred. They appreciate the services provided by the MCH. "When you attend the clinic for the first time you are weighed, examined, and vaccinated. If the MCH nurses find anything wrong with you they will refer you to the doctor who gives the correct medicine."

The periodic vaccination schedule often creates hardship for mothers who do not live in Kibaoni. Although vaccination days are announced in advance, a flooded road--common in the rainy season, can prevent a woman from a neighboring village access to the MCH clinic on that particular day. Several of the mothers mentioned the reprimands they received from the MCH nurses when their failure to report was noted.

4.8 MCH CLINIC IN KIBAONI

The MCH clinic is housed in a four room building with a veranda that serves as a receiving room. It is not well cleaned and the ceiling is missing tiles. The grass around it is tall and debris litters the grounds; however, inside, operations run smoothly. The MCH clinic provides growth monitoring, antenatal care, family planning services, referral systems, and health education. Immunization clinics are run periodically and are not provided on a daily basis. The services are provided free of charge, but the MCH clinic no longer regularly provides drugs or treatment for illnesses and must refer patients to dispensaries, which face their own drug shortage problems.

At the time of the researchers' visit five aides staffed the clinic. These aides were trained as nurses and had midwifery training as well. During the observation period three of them attended to the mothers, providing antenatal services and family planning advice and aids.

The observers witnessed a first time mother receiving fairly extensive medical attention, eg, blood pressure, weight, and medical history. At the time of the observation an aide had just returned from the hospital with a supply of birth control pills and a diaphragm with jelly. She delivers these contraceptives bi-weekly from Ifakara and a woman must present empty packets of pills to receive more. The group noted that the woman receiving the pills wrapped them in cloth, perhaps so as not offend the sensibilities of other patients, or to hide them from their husbands or family members.

A lecture for health information was conducted by one of the aides. It lasted for about 15 minutes and the mothers, nearly 80 of them, were very attentive. It was a lecture on cholera; how to prevent it and how to recognize the disease. During the early part of the session, a brief review of the past lessons on malaria and other diseases was conducted with active participation from the audience. The aide appeared to be an effective communicator.

A cursory look at the health card of a few children revealed that the vaccination program was being followed. The date of the next visit was also written down on the card. A cold chain bag was also visible in one of the rooms, alongside sterilization basins, a sterilizer, some syringes and a stove. All of these indicate that the EPI is an integral service of the clinic.

The mother-child clients came not just from Kibaoni but other village compounds as well. They came on foot, mostly in pairs or groups, but none was accompanied by a man. The mothers ranged in age from 14-35 years with an estimated average of 20-25. Most were dressed plainly and looked rather poor. The children were between seven months to two years. They were generally poorly nourished. A few had cough, skin infections or eye infections.

Within the MCH clinic the researchers noted the following equipment: an examining table, stethoscope, blood pressure apparatus, two fetuscopes, two bathroom scales, boxes of contraceptive

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pills, boxes of diaphragm with jelly, a carton of patient's records, sterilizer, stoves, basins, cold chain bag, and syringes. However, the notable absence of cabinets, drugs, refrigerators and a sink indicate how limited the scope of the MCH services are.

By and large, the researchers considered the provider-client relationship to be satisfactory. Despite the large turnout for the growth monitoring activity, the aides remained unperturbed. One of the aides sometimes even managed to advise the mothers on proper nutrition. An old women who came with a child who was not her own was emphatically told by one of the aides that the mother should always come with the child. The mother would then receive health information which would benefit both the child and the mother.

With the exception of the district hospital, the MCH clinic in Kibaoni is perhaps the most frequently utilized modern health service in the village area. Despite the drug shortages the clinic provides a stable and well appreciated service to the community. Immunization and growth monitoring are government policies and the mothers seem interested in complying with them because they are perceived to be of direct benefit to their children. Some clients come as well because they are interested in health issues and they find the lectures informative.

4.9 PROVIDER PERSPECTIVES

The researchers interviewed the six MCH aides and the health assistant from the MCH clinic in Kibaoni. They listed malaria, diarrhoea, meningitis, hookworms, and cholera as significant health problems for the community they serve. Because transportation to the clinic is limited to foot or bicycle, the patients, who often come from more than five kilometers away, usually wait to seek treatment until their symptoms become serious. One aide described typical patient behavior this way:

> When the patient starts to feel headache, they say 'let us wait, perhaps it will feel better tomorrow.' And that makes people come here to late for treatment, and the condition of the patients to be worse.

The aides were further hampered by the lack of drugs available to them. The drugs come at the first of the month, and when they are depleted patients have to be referred to the hospital in Ifakara. "Sometimes they (patients) get only the registration card. How do you think they feel when they get only the card and no drugs?" When the drugs are not available patients must resort to dispensaries where, if drugs are available, they must be purchased. The aides felt this led many patients to treat themselves or turn to traditional healers. "Some of them opt to go home and then they stay at home caring for themselves. And sometimes they die at home."

The search for drugs is time consuming and frustrating. A pregnant mother requiring drugs or diagnostic tests may spend most of a day walking from her village to Kibaoni, from there to a dispensary lab, only to be sent to the hospital in Ifakara.

> When we send them to the dispensary laboratory for lab investigations, sometimes the reagents are not there. The same mother comes back and then we send her to the town hospital to get lab investigations. She is told to register and she continues to have to pass through all these formalities again. Sometimes they ask her to pay 200 T.Shs for the card. So they go back and wait for the dispensary lab to get reagents. Sometimes they have been examined already here but they may not believe the results there, so they have to be examined again. And when they are examined there they find that there is no problem, so they are sent back here, although they have paid the 200 T.Shs.

On the whole the MCH aides enjoyed their work and found it satisfying, though they were frustrated at their inability to provide drugs and better treatment for their patients. When asked what other equipment they needed they listed transportation for outreach services, more scales, and equipment and personnel to clean the surroundings.

4.10 NUTRITION

There is a marked awareness of the need for better nutrition for pregnant mothers. One young mother stated it thus: "During pregnancy a woman needs to have adequate food, but because we usually do not have enough food, our children have to eat first. In most cases, therefore, the mother has to sleep hungry. This contributes to complications during pregnancy."

Anemia is a common health complaint among women in the community, and during pregnancy this condition is exacerbated by poor nutrition. Seasonal rains also hamper food procurement, particularly limiting protein consumption. Attempts to educate the women in the community on nutritional requirements have suffered from a lack of resources and are now viewed with cynicism. For example, in Lower Kilama the village has a "nutrition day" about every two months where mothers are taught how to make nutritious porridge for their children. However, the village no longer supplies the soya milk powder it once did and now the women of the village complain about "nutrition day:"

> ...these days we are asked to carry flour from our own houses. Sugar, the village gives us. Water, too, the village gives us. But when I think of it I can't understand. At home I make the very porridge with the very flour and the very sugar and then I go there and I have to make the same porridge with the same sugar. Now I wonder, am I there to show the way I cook or what is it? If it's really a nutrition day they should give me the flour and the sugar and tell me how I should feed my child. But then, we still have to carry the stuff and cook there. I don't understand this nutrition day business.
>
> ...and not everyone brings the same type of flour. Some bring millet flour, others bring cassava flour, others bring "kimeya", others bring "ulesi." And all this becomes some mixture. And now you wonder what sort of nutrition day is this when the children have to be given this mixture? Some may not react to it well; in fact, sometimes you get home and the child starts to get diarrhoea. To be truthful we are fed up with this nutrition day.

4.11 CHILDHOOD ILLNESSES

The children in this area suffer from a wide range of illnesses, from the common cold to cerebral malaria. Diarrhoea is the most common serious illness, generally stemming from unclean drinking water, poor hygienic practices, and the lack of latrines. Respiratory infections, measles, chicken pox, and whooping cough also take their toll. Many of the children also suffer from malnutrition in varying degrees which inhibits their ability to withstand diseases.

Cerebral malaria affects many children. The researchers found very few bednets in the houses they visited, though there was widespread knowledge of the effectiveness of bednets in preventing malaria. Children suffering from malaria are generally taken to modern health services if their symptoms are severe. Cerebral malaria is feared by most parents because of the difficulty in treating it and its dramatic convulsive symptoms. In these cases traditional healing is often sought because of a perceived inability of modern methods to cure the disease.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

The purpose of this report was to describe and analyze the major health problems, treatment seeking behavior, and types of health services available in the village of Kikwawila in rural Tanzania. The researchers used qualitative methods such as focus group discussions, semi-structured interviews, and in-depth interviews to gather their data which will be useful in developing an effective health improvement strategy for this or similar communities.

The poor infrastructure, which includes lack of electricity and transportation facilities, plays a detrimental role in the health and welfare of this community. For example, the cessation of mosquito spraying and the high cost of bednets contribute to the high endemicity of malaria.

The most prevalent diseases are malaria, dysentery, schistosomiasis, intestinal helminths, and diarrhoea. The respondents exhibited widespread knowledge of these diseases, their etiologies, and methods of prevention. Treatment seeking behavior includes utilization of modern health services in the form of dispensaries, health posts and a district hospital. However, the high cost of modern treatment and the pervasive scarcity of drugs and diagnostic tools, in addition to transportation difficulties, often limit the efficacy of modern services. The lack of drugs may lead to an increase in black market drug peddling which could further undermine efforts by health authorities to provide inexpensive treatment at government facilities.

Parallel health services are frequently utilized. These services include traditional healers who provide alternative treatment and birth attendants. Traditional methods are typically sought in cases where diseases are present in a milder form or, conversely, where they are so serious that modern services are perceived to have failed.

Traditional birth attendants are most often utilized by experienced mothers or when labor begins in the evening because transportation to the district hospital at night is so difficult.
The status of TBAs is in their villages is variable, but their contribution is valued by MCH workers who recognize them as playing an important role in decreasing maternal mortality.

Many respondents felt that health services improved when small fees were charged for treatment. However, some respondents mentioned encountering class and gender biases when seeking treatment. Poorly dressed patients in some cases were less likely to receive drugs, even when they were available. Women sometimes faced sexual harassment from male health workers who provided drugs or treatment in exchange for sexual favors.

The vast majority of the respondents listed the district hospital as the only viable source for treatment of the most serious endemic diseases. The other modern services, e.g. dispensaries and health posts, provide unreliable care due to drug and equipment shortages. At these facilities health care workers were often frustrated or demoralised by their inability to provide competent services due to these shortages.

The Maternal and Child Health Clinic in Kibaoni provides extensive and well attended educational programs on health issues for the community. Furthermore, their vaccination programs are generally thorough, though infrastructural impediments occasionally limit their effectiveness. Due to an irregular supply of drugs most illnesses are referred to other facilities which creates further hardship for mothers and their children.

Nutritional needs for mothers and their infants are not always met satisfactorily. Programs such as "nutrition day" are viewed with cynicism due to a lack of substantive improvement in dietary quality. Milk and soya proteins are particularly found lacking.

Meeting health needs in this area is particularly challenging due to the many economic difficulties faced by the people and the government of Tanzania. However, as this report describes, the study population was highly knowledgeable about its health problems. In some cases, people simply lacked the economic means to improve their health status, and in other cases, the power to overcome cultural barriers between themselves and the health system. Nonetheless, there are specific strategies that may be effective and acceptable to the community and health care workers.

RECOMMENDATIONS

1. Efforts should be made to provide better access to safe water and latrines. Since the water table is known to be high in the village, the local leadership should be assisted to ensure that pit latrines that are full are covered and new ones are built immediately by the villagers.

2. The local authorities, in collaboration with the community and the Ministry of Water, Energy and Natural Resources, should work on the provision of piped water into these communities.

3. The local authorities, in collaboration with the community and Ministry of Health, should ensure the operation of a functional health care centre in each village with adequately trained staff. This would include providing the following:

    a. At least one female health worker in each health post.

    b. Diagnostic equipment such as apparatus to measure hemoglobin levels, blood pressure apparatus, gloves, thermometers, weighing scales, syringes, and stethoscopes.

    c. Regular and sufficient supplies of drugs such as antibiotics, pain killers, oral rehydration packets, and malaria tablets.

    d. Clean water, medicated soaps, refrigerators, and a regular supply of electricity.

    e. Further training and adequate supervision of health staff.

    f. Increased salaries, staff uniforms, and improved housing for health staff.

4. As the community appears willing to use bednets, efforts should be made to provide them at a subsidized cost, as well as corrugated iron sheets for latrines and housing, insecticides and spraying equipment.

5. Critical examination and improvement of child nutritional services is required.

6. Provision of time saving technologies for women such as a milling machine would be a great asset to the community.

7. Development of alternative payment schemes for formal health services such as cooperatives, bartering, and payment in kind is recommended.

8. Traditional healers should be better utilised in the delivery of health education and health services by:

   a. Improving the dialogue and interaction between traditional and modern services.

   b. Training of traditional healers on basic hygiene practices.

   c. A referral system should be encouraged between traditional and modern health services that takes into account the respective strengths and weaknesses of each.

9. TBAs should receive on-going education and support for their services. TBAs should be provided with the following material: medicated soaps, towels, gloves, basins, hurricane lamps, and razors.

10. The local authorities should provide incentives to attract female health workers, particularly physicians, to the area.

APPENDIX
LIST OF PARTICIPANTS:

TDR/WHO QUALITATIVE METHODS WORKSHOP
Ifakara, Tanzania, 11 - 29 April 1994

Participants

Mr Collins Ahorlu
Noguchi Memorial Institute
for Medical Research
P.O. Box 25
LEGON / Ghana

Mr Moses Aikins
Department of Public Health & Policy
Health Policy Unit
London School of Hygiene & Tropical Medicine
Keppel Street
LONDON WCIE 7HT / England

Dr William Kwadwo Asenso-Okyere
University of Ghana
Institute of Statistical,
Social and Economic Research,
P.O. Box 74
LEGON / Ghana

Dr Moses J. Bockarie
Institute of Medical Research
P.O. Box 378
MADANG / Papua New Guinea

Mrs Muriel Harris
Society for Women and AIDS in Africa
30A Wallace Johnson Street
P.O. Box 603
FREETOWN / Sierra Leone

Dr Athula B. Herath
Malaria Research Unit
Department of Parasitology
University of Colombo
Faculty of Medicine
P.O. Box 271
Kynsey Road
COLOMBO 8 / Sri Lanka

Dr. Leykun Jemaneh
Associate Professor and Head
Dept of Microbiology and Parasitology
Faculty of Medicine
Addis Ababa University
P.O. Box 9086
ADDIS ABABA / Ethiopia

Ms Margaret M. Kitonga
African Biodiversity Institute
A.A.C.C. Building, Waiyaki Way
P.O. Box 14126
NAIROBI / Kenya

Mr J.H. Ranjit Kumar
Community Health Department
Christian Medical College
VELLORE 632OO2 / India

Dr Theresita R. Lariosa
Dept. of Medical Microbiology
College of Public Health
University of the Philippines
625 Pedro Gil St., Ermita
P.O. Box EA-460
MANILA 1000 / The Philippines

Mrs. Euphemia T. Massamu
Preventive Department
Malaria Unit
Ministry of Health
P.O. Box 3855
DAR ES SALAAM / Tanzania

Ms Maria Bernarda Meneghini
Centro de Estudios Sanitarios y Sociales
Asociacion Medica de Rosario
Espana 401
ROSARIO 2000 / Argentina

Ms Hayet Moussa
Ministère de la Santé Publique
Direction des Soins de Santé de Base
28 rue Cyrus le Grand
Lafayette 1002
TUNIS / Tunisie

or Tour Africa
Bureau 345
50 Avenue Bourguiba
TUNIS / Tunisie

Mr Martin Mushanga
Tropical Diseases Research Centre
P.O. Box 71769
NDOLA / Zambia

Dr J.K. Nguma
Institute of Public Health
Muhimbili University College
of Health Sciences
P.O. Box 65015
DAR ES SALAAM / Tanzania

Prof. (Mrs) Adetanwa I. Odebiyi
Head, Department of Sociology and Anthropology
Obafemi Awolowo University
ILE-IFE / Nigeria

Dr E.B.L. Ovuga
Department of Psychiatry
Faculty of Medicine
Makerere University
P.O. Box 7072
KAMPALA / Uganda

Ms Denise Vogel
Route de la Douane
F- 01220 SAUVERNY / France

Observers

Mrs. Christine Hatz
University of Basel / Switzerland
c/o Swiss Tropical Institute

Mr. Charles Mayombana
Morogoro Schistosomiasis Project
P.O. Box 1308
MOROGORO / Tanzania

Mr Cyril Pervilhac
Project Coordinator
Ifakara Centre
c/o NIMR HQs
PO Box 9653
DAR ES SALAAM / Tanzania

RS-130
04867
COMMUNITY HEALTH CELL
LIBRARY
AND
DOCUMENTATION
UNIT
BANGALORE.

Resource People

Dr Kale Feyisetan
Dept of Demography and Social Statistics
Obafemi Awolowo University
ILE-IFE / Nigeria

Dr Anu Kumar
Human Reproduction Programme (HRP)
WHO
Av. Appia
1211 GENEVA / Switzerland

Dr Halima Mwenesi
Kenya Medical Research Institute
Medical Research Centre
P.O. Box 20752
NAIROBI / Kenya

Dr. Brigit Obrist van Eeuwijk
Ethnologisches Seminar
der Universitat Basel
Munsterplatz 19
4051 BASEL / Switzerland

Prof Marcel Tanner
Swiss Tropical Institute
Dept of Public Health and Epidemiology
Socinstrasse 57
P.O. Box
4002 BASEL / Switzerland

Dr Carol Vlassoff
TDR/WHO
Av. Appia
1211 GENEVA 27 / Switzerland

Dr. Mitchell Weiss
Clarke Institute of Psychiatry University of Toronto
250 College Street
TORONTO Ontario M5T 1R8 / Canada